WELLPARTNER PHARMACY | ONCOLOGY ORAL MEDICATIONS ENROLLMENT FORM

Wellpartner

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

ICD-10 Code	Description

Height (in/cm): _____ Weight (lb/kg): _____ BSA (m^2): _____

Pregnancy Category:

- ◯ Adult female of childbearing potential
- ◯ Adult female **not** of childbearing potential
- ◯ Female child of childbearing potential
- ◯ Female child **not** of childbearing potential
- ◯ Adult male
- ◯ Male child

Allergies:

Other Conditions:

Other Medications:

Previous Therapies:

5. PRESCRIPTION INFORMATION

Medication	Dose	Directions	Qty	Refills	Medication	Dose	Directions	Qty	Refills
◯ Afinitor® (everolimus)					◯ Purixan (mercaptopurine)				
◯ Afinitor Disperz					◯ Revlimid® (lenalidomide) **(LD)***				
◯ Alecensa (alectinib)					◯ Sprycel™ (dasatinib)				
◯ Bosulif® (bosutinib) **(LD)***					◯ Stivarga® (regorafenib) **(LD)***				
◯ Cabometyx (cabozantinib) **(LD)***					◯ Sutent® (sunitib malate) **(LD)***				
◯ Cotellic (cobimetinib)					◯ Tafinlar™ (dabrafenib)				
◯ Erivedge™ (vismodegib)					◯ Tagrisso (osimertinib)				
◯ Farydak (panobinostat) **(LD)***					◯ Tarceva™ (erlotinib)				
◯ Gleevec® (imatinib mesylate)					◯ Targretin® (bexarotene) capsules				
◯ Hycamtin® (topotecan HCl)					◯ Tasigna® (nilotinib)				
◯ Ibrance (palbociclib) **(LD)***					◯ Temodar® (temozolomide) capsules				
◯ Iclusig™ (ponatinib) **(LD)***					◯ Thalomid® (thalidomide) **(LD)***				
◯ Inlyta® (axitinib) **(LD)***					◯ Tykerb® (lapatinib)				
◯ Iressa (genfitinib)					◯ Votrient® (pazopanib)				
◯ Jakafi™ (ruxolitinib) **(LD)***					◯ Xalkori® (crizotinib) **(LD)***				
◯ Lonsurf (trifluridine & tipiracil) **(LD)***					◯ Xeloda® (capecitabine)				
◯ Mekinist™ (trametinib)					◯ Xtandi® (enzalutamide)				
◯ Nexavar® (sorafenib) **(LD)***					◯ Zelboraf® (vemurafenib)				
◯ Ninlaro (ixazomib)					◯ Zolinza® (vorinostat)				
◯ Odomzo (sonidegib) **(LD)***					◯ Zykadia™ (ceritinib)				
◯ Pomalyst® (pomalidomide) **(LD)***					◯ Zytiga™ (abiraterone)				

(LD)* These are limited distribution drugs that require additional handling. Please call (1.800.473.3516) for more information.

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED DATE